STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE COMPL	ETED	
		133010	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	03/09/2	011
NAME OF F	PROVIDER OR SUPPLIER			201 E E			
	ARK NURSING AND	REHABILITATION		NEW A	LBANY, IN47150		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
F0000	This visit was of Complaint	for the Investigation	F00	00			
		11 10 00 00 00 7 .					
	Complaint IN	00086657:					
	Substantiated	- Federal/State					
	deficiencies re	elated to the					
	allegations are	e cited at F272, F279,					
	F282, F309, a	nd F441.					
	Unrelated defi	ciencies cited.					
	Survey dates:	March 8 and 9, 2011					
	Facility numb	er: 001145					
	Provider numb						
	AIM number:	200120200					
	Survey team:	Jennie Bartelt, RN					
	Census bed ty	pe:					
	SNF/NF: 74	-					
	Residential: 1	7					
	Total: 91						
	Census payor	type:					
	Medicare: 12						
	Medicaid: 54						
	Other: 25						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6ZJX11

Facility ID:

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155616			A. BU	ILDING	NSTRUCTION	COMP1	LETED
	NO. A TOTAL CO. T.		B. WI		DDRESS, CITY, STATE, ZIP CODE	30/03/2	
	PROVIDER OR SUPPLIER			201 E E	LM ST		
	ARK NURSING AND				_BANY, IN47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	Total: 91						
	Sample: 7						
		in accordance with					
	Quality review Cathy Emswil	v completed 3-15-11 ler RN					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155616	B. WIN			03/09/2	011
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				201 E E			
LANDMA	RK NURSING AND	REHABILITATION		NEW A	LBANY, IN47150		.
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TΕ	COMPLETION DATE
F0176		ervation, interview,	F01		F176 483.10(n) RESIDENT		04/08/2011
SS=D		riew, the facility		, 0	SELF-ADMINISTER		0 1/ 0 0/ 2011
33-D		•			DRUGS IF DEEMED SAFE It is the practice of Landmark		
		re a resident who was			Nursing & Rehabilitation to		
		ring respiratory			assure an individual resident r	may	
		ad assessment and			self-administer drugs if the interdisciplinary team, as		
	1	ers related to the self			defined by		
		of the medication.			§483.20(d)(2)(ii), has determin	ned	
	The deficient j	practice affected 1 of			that this practice is safe.		
	1 resident revi	ewed related to self			produce to date.		
	administration	of medication in a			I. Resident B was assess		
	sample of 7. (	(Resident B)			for the ability to self administer medications. This assessmen		
					was completed by R.N. in conjunction with IDT. This		
	Findings inclu	ide.			assessment was placed in Resident B's clinical record.		
	During the Ini	tial Tour on 3/8/11 at			Resident B's care plan was updated to reflect the self		
	6:50 p.m., Res	sident B was observed			administration of medications.		
	in bed. A han	d-held inhaler and a			Resident B was provided with	а	
	nebulizer treat	ment machine were			calendar to document the provision of self medications		
	observed on th	ne bedside table next			readily accessible to nurses to	)	
	to the resident	. During interview at			review. II. All Residents were		
		resident indicated he			reviewed for the desire to self		
	· ·	nis inhaler, motioned			administer medications. All		
		er treatment machine,			residents who verbalized the desire to self administer		
		he would be using his			medications will be assessed	and	
		ment shortly. The			care plans will be updated accordingly.		
		ated he was able to			III. Self Medication Policy		
					was reviewed by QA and found		
		hanage the medications himself.  he resident indicated he moved			be appropriate. All nurses we educated on the Self Medication		
	The resident ii	narouted no moved	red		Policy		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAIN	OF CORRECTION	155616	A. BUILDING			03/09/2011
		100010	B. WIN		ADDRESS CITY STATE ZIR CODE	00/03/2011
NAME OF F	PROVIDER OR SUPPLIER			201 E E	ADDRESS, CITY, STATE, ZIP CODE	
	RK NURSING AND	-		1	LBANY, IN47150	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
1/10		y from "upstairs"		1710	IV. The Care Plan	DAIL
		g section of the			Coordinator will maintain the o	
	,	a week earlier.			plans for those residents desir to self administer medications.	·
		a wook carrier.			These care plans will be revie	
	Review of a lis	st of "Interviewable			no less frequently than quarter and with any significant chang	
		vided by the Director			status. During the care plan	
		er the Entrance			review process, the self administration of medication	
	_	dicated Resident B			assessment will be updated to	
	was interviewa				reflect each resident's current status. The Care Plan	
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Coordinator will report to QA	
	The clinical re	cord for Resident B			monthly for 3 months and ther	n
		on 3/8/11 at 11:00			quarterly. COMPLETION DATE:	
		rd indicated the			04/08/2011	
	•	dmitted to the facility				
		e resident's diagnoses				
		were not limited to,				
	COPD (chroni					
	pulmonary dis					
	pullionary dis	ease).				
	Physician's ord	ders for 3/1/11				
	_	1 included, but were				
	_	"Duoneb 2.5 - 0.5				
	mg 3 ml/sol [n					
		oronchospasm], 1 vial				
	_	as needed SOA				
	-					
	[shortness of air] /wheezing" and "Ventolin HFA [bronchodilator					
	medication] 90	) mcg [micrograms],				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155616		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY  COMPLETED		
		155616	B. WING			03/09/2	011
	PROVIDER OR SUPPLIER		2	201 E E	DDRESS, CITY, STATE, ZIP CODE LM ST .BANY, IN47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	Take 2 puffs e needed, SOA.'	very 4 hours as					
	Record for Mathe Duoneb had one time on 3/p.m.] not indicated the During intervipum, the Direct (DON) indicated have a written self-administration of Medication indicated the inform should be residents self a medications. The form indicated	nts section of the rd failed to indicate related to ation of medications.  ew on 3/9/11 at 2:30 etor of Nursing red the facility did not policy related to ation of medication.  vided copy of a blank related to a blank rela					

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			MULTIPLE CO TLDING		COMPL		
		155616	B. WI				03/09/2	011
	PROVIDER OR SUPPLIER			201 E E	DDRESS, CITY, STATE LM ST BANY, IN47150	E, ZIP CODE		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DO OVER THE OWN AND AND AND AND AND AND AND AND AND AN	V OF GODDESSTORY		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED	TO THE APPROPRIATI	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICII	ENCY)		DATE
	self administer	r medications. There						
	must be a phys	sician's order to self						
	administer and	the order must be						
	specific as to v	which medication(s).						
	Complete re-a	ssessment quarterly						
	or with signific	cant changes in the						
	_	lition." The DON						
	indicated to he	er knowledge, no						
		inistered medications						
		The DON indicated						
		ist have administered						
		cations when he was						
		l" (assisted living						
	section of facil	,						
	continued to d	• /						
	continued to d	0 80.						
	Physician's ord	ders failed to include						
	an order for th	e resident to						
	self-administer	r the medication.						
	3.1-11(a)							
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	6ZJX11	Facility I	ID: 001145	If continuation sh	eet Pa	ge 6 of 54

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	155616	A. BUII		03/09/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER				ELM ST	
	RK NURSING AND			NEW A	LBANY, IN47150	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
F0272		rvation, record	F02	72	F272 483.20, 483.20(b)	04/08/2011
SS=D	review, and in	terview, the facility			COMPREHENSIVE ASSESSMENTS	
	failed to ensur	e wounds were			It is the practice of Landmark	
	assessed and re	eassessed on a			Nursing & Rehabilitation to conduct initially and periodical	lv a
	weekly basis for	for 2 of 4 residents			comprehensive, accurate,	
	-	ed to wound care in a			standardized reproducible	
	sample of 7. (	Residents D and G)			assessment of each resident's functional capacity.	
	Findings inclu	de:			I. Complete skin checks wound assessments were completed for Resident D and	and
		Initial Tour on 3/8/11			Resident G by licensed nurses These wound assessments	S.
	at 6:50 p.m., R	Resident D was			continue to be done weekly an	nd
	interviewed.	The resident indicated			documented in the Residents' clinical records on the Weekly	
	she was very h	ard of hearing and			Wound Evaluation Flow Recor	
	requested com	munication with			by licensed nurses.  II. Complete skin checks	will
	notes written o	on paper she			be completed on all residents.	
	provided. She	indicated she had a			wounds will be identified and	
	boil on her leg	and pointed to the			assessed by licensed nurse. These assessments will be	
	left leg above	the knee. The			documented in the residents'	
	_	I the door to her			clinical records on the Weekly Wound Evaluation Flow Recor	
	room, and she	pulled her pants			Weekly reassessment by	<u>"</u>
	below the knee	• •			licensed nurses will be ongoin	~ I I
	dressing on the	e wound. A Telfa pad			and documented in the resider clinical records on the Weekly	
	_	above the left knee.			Wound Evaluation Flow Recor	
					III. LPN #12 will be reeducated on wound	
	The clinical re	cord for Resident D			assessment, physician's order	s
		on 3/8/11 at 10:55			and notification of physician	
	p.m. The resid				regarding changes in skin condition. Wound Evaluation	and
	p 1110 10510	THE CHILDREN			Treatment Policy was reviewed	d by

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155616	B. WIN			03/09/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			201 E E	ELM ST		
	RK NURSING AND	REHABILITATION			LBANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	
IAG		a Set assessment		IAG	QA and found to be appropria		
		ndicated the resident			All nurses will be reeducated of	on	
		ent in cognitive skills			the Wound Evaluation and Treatment Policy. Nurses will		
	_	ion-making, could			complete skin checks as		
	-				prescribed by physicians. The results of these skin checks w		
	•	d was able to make			be documented on the back o		
	herself underst	ioou.			the resident's Treatment		
	A Nursa's Note	e dated 2/17/11 at			Administration Record. C.N.A will continue to complete skin	S	
					documentation with each show	-	
	_	dicated, "N.O. [new			and turn in completed shower sheets to nurse. Nurse will		
	_	t faxed for warm			review these sheets for any		
	compress to bo	oil on L [left] thigh			changes in skin condition not		
	BID [twice dat	ily] then apply TAO			identified through prescribed s	skin	
	[triple antibiot	ic ointment] & cover			checks. Should a wound be identified by any means, the		
	[symbol for w	ith] telfa. Area			nurse will assess the wound a	nd	
	around boil red	ddened, scant amt			document the assessment on Weekly Wound Evaluation Flo	w	
	[amount] of cl	ear drainage noted.			Record		
	Will cont [con	tinue] to monitor."			IV. The DON will review shower sheets daily. The DO	N I	
	No further doc	cumentation since this			will oversee the IDT review of		
	note was indic	ated in the Nurse's			wounds no less often than		
	Notes section	of the clinical record.			weekly. This review will include but not be limited to visualization.		
					of the wound and wound		
	An Interdiscip	linary (IDT) Progress			assessment documentation. DON will report to QA monthly		
	Note dated 2/1	, , ,			3 months and then quarterly.		
		icated, "Resident			V. COMPLETION DATE:		
	,	ith] boil present to L			04/08/2011		
	thigh & orders						
	~						
	compresses. See NN [Nurse's						
	Note] of 2/17/11." No further						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155616			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY  COMPLETED		
		155616	B. WING			03/09/2	011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  201 E ELM ST  NEW ALBANY, IN47150					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
	documentation indicated in the Progress Note clinical record.  The Medication Skin Check Sh 2011 indicated was completed 2/19/11. The Visheet indicated "Open area: Con 2/26/11 and undated "Weel Sheet" in the Minder at the mind	a since the note was e Interdisciplinary section of the  In Record and Weekly leet for February In o skin assessment If as scheduled on Weekly Skin Check If the resident had an old" on the right thigh If an unsigned, If skin Check If dedication Record If the dedication Record If the dedication cart for If all indicated: "Other: If thigh."			CROSS-REFERENCED TO THE APPROPRIA	NE		
	p.m., the Direct (DON) indicate not have a special but she or the A Nursing (ADC once a week. documentation	etor of Nursing ed the facility does cific wound nurse, Assistant Director of ON) look at wounds She indicated a would be in IDT n sheets on the TAR						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	
		155616	B. WINC			03/09/2	011
NAME OF F	PROVIDER OR SUPPLIER	<b>"</b> {		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
			201 E E				
	RK NURSING AND	REHABILITATION		NEW AI	LBANY, IN47150		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)	1	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
1710		dministration Record].		1710			DAIL
	[ Heatiment At	illillistration Records.					
	0 2/0/11 . 1	0.50 LDV.					
		2:50 p.m., LPN #6					
	was observed	providing the					
	treatment to R	esident D's left thigh.					
	Resident D pu	illed her pants below					
	the knees, and	the dressing on the					
	left thigh indi	cated 3/8/11, 8:15					
		removed the soiled					
	_	resident indicated, "It					
		filling back up." The					
		d there was no					
	_	e wound was observed					
	-	llow in the center					
	surrounded by	a red rim and dark					
	around the eda	ges under the skin.					
	During intervi	ew at this time, LPN					
	#6 indicated	documentation should					
	be in the recor	d about the wound					
	size, and she i						
		current size by					
		umb to the first					
	1						
		r middle finger to					
		oximate size of the					
	wound.						
	During intervi	lew on 3/9/11 at 2:30					
	p.m., the DON	I indicated the facility					
		-					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				AULTIPLE CO. ILDING	NSTRUCTION	COMPI	
		155616	B. WI			03/09/2	2011
	PROVIDER OR SUPPLIER			201 E E	DDRESS, CITY, STATE, ZIP CODE LM ST LBANY, IN47150	'	
	summary's (EACH DEFICIENT REGULATORY OR did not have we policies. She is assessment of nurse would we see that form on a Review of the indicated informstage, length, we presence of untype and amout and surrounding type.  During interviews on the propose of the propose of the indicated informstage, length, we presence of untype and amout and surrounding type.	REHABILITATION  TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  Tritten wound care indicated related to the wound that a trite what she sees. wed a Weekly Wound ow Record for another idicated she would the information on wound assessment. Flow Record mation including width, and depth, dermining, exudate int, tissue description, and skin color and  ew on 3/9/11 at 4:45 I indicated she had nurse, who told the	- 1	STREET A 201 E E	LM ST	N EE	(X5) COMPLETION DATE
	noted, but the it down. The local d find no dindicate the wo	nd when it was first nurse forgot to write DON indicated she documentation to					
	indicated she o	could not find a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155616			ULTIPLE CO	NSTRUCTION	(X3) DATE S	ETED	
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NAME OF F	PROVIDER OR SUPPLIER			201 E E	DDRESS, CITY, STATE, ZIP CODE		
	ARK NURSING AND			NEW AL	LIN 01 LBANY, IN47150		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
	Weekly Wound	d Evaluation Flow					
	1	sident D's wound.					
	2 The clinica	l record for Resident					
		ed on 3/8/11 at 9:40					
		dent's diagnoses					
	_	were not limited to,					
	· · · · · · · · · · · · · · · · · · ·	ripheral vascular					
		specified venous					
	insufficiency.	<b>.</b>					
	   Weekly Skin (	Check Sheets for					
	1	March 2011 indicated					
	1	on 2/5, 2/12, and					
	_	esessment indicated					
		d "Open area: Old."					
		n failed to indicate a					
	skin assessme	nt was completed on					
		imentation on 3/5/11					
		n Intact." Weekly					
		ation Flow Records					
	from 1/19/11 t						
		esident was being					
		on-pressure ulcer to					
	the left ankle.	•					
	A physician's of	order was received on					
	2/22/11 for "C	leanse R [right] ankle					

AND PLAN OF CORRECTION IDENTIFICATION NUM  155616	VIDLA.			COMPLETED
		ILDING		03/09/2011
	B. WIN		DDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER		201 E E		
LANDMARK NURSING AND REHABILITATION		NEW AL	BANY, IN47150	
(X4) ID SUMMARY STATEMENT OF DEFICI		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDE TAG REGULATORY OR LSC IDENTIFYING INF		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
[symbol for with] NS [norma				
saline] apply Aquacel AG [al	I			
cover [symbol for with] Vers	siva X			
C & wrap [symbol for with]	Kerlix			
q [every] 3 days & PRN [as r	needed]			
for soiled/dislodged."	-			
Documentation in Nurse's No	otes			
from 2/22/11 through date of	f			
review or on a Weekly Woun	nd			
Evaluation Flow Record fails	ed to			
indicate a description of the	wound.			
Documentation on the Medic				
Records for February and Ma	I			
2011 next to the entry for the				
dressing change indicated the	I			
dressing was changed on the				
following dates: 2/22, 2/25,	´			
and 2/28/11 and 3/3, 3/5, 3/6	, and			
3/7/11.				
Nurse's Notes for 2/25/11 at	1:20			
p.m., indicated, "Tx [treatn	- I			
bilat [bilateral] ankles compl				
ordered." No other Nurse's				
indicated information about t	the			
wound to the right ankle.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M A. BUI		NSTRUCTION	(X3) DATE S		
		155616	B. WIN			03/09/2	011
	PROVIDER OR SUPPLIER		_ <b>!</b>	201 E E			
	ARK NURSING AND			<u> </u>	_BANY, IN47150		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE
	During intervieue, m., the DON station and restrected for information wound. LPN and nurse's station resident had won both ankles in treatments. telephoned the who had cared day shift on 3/ indicated to the atreatment to ankle today but treatment to the because there we treat." The DO she had obtain to discontinue LPN #12 indicated the principal indicated the prin	ew on 3/9/11 at 4:45 I was at the nurse's earched the resident's rmation about the #3 was seated at the and indicated the ounds come and go with lots of changes The DON nurse, LPN #12, for Resident G on 9/11. LPN #12 e DON she provided the resident's left at did not provide the e right ankle, was "nothing to DN asked LPN #12 if ed a physician's order the treatment, and eated she had not ohysician. The DON #12 told her she had Wound Evaluation elated to the right					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	ľ í	E SURVEY PLETED
111,2 12,111	or conduction	155616	A. BUILDING B. WING		03/09/	
NAME OF I	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP	CODE	
				E ELM ST		
	ARK NURSING AND			/ ALBANY, IN47150		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	DATE
	the Flow Reco	rd.				
	On 3/9/11, imi	mediately after the				
	DON complete	-				
	conversation v					
	Resident G's ri	~				
		DON and LPN #3				
		esident to his room				
		nis white sock. Two				
	small areas of bright red blood were					
		he resident's lower				
		lark red, and the skin				
	-	o open areas oozing				
	_	uid were observed on				
		e right shin. A dark				
		n under the skin was				
		ne top of the foot. No				
	dressing was p					
	_	ankle. The top of				
		eolus had a dull dark				
		appeared firm and				
		ssed. No drainage				
		LPN #3 ran her				
	_	e area and indicated				
	_	n. The resident asked				
	_	is in the wound, and				
	LPN #3 told hi	im there was not.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION	(X3) DATE : COMPL 03/09/2	ETED	
NAME OF F	PROVIDER OR SUPPLIER		P		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
LANDMA	RK NURSING AND	REHABILITATION		NEW AL	BANY, IN47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	This federal ta	g relates to					
	Complaint IN(	00086657.					
	3.1-31(c)(2)	J008663 / .					

				JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED
		155616	B. WIN			03/09/2011
NAME OF P	PROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE	
ΙΔΝΏΜΔ	RK NURSING AND	REHARII ITATIONI		1	ELM ST LBANY, IN47150	
					i	75
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F0279	Based on obse	rvation, interview,	F02	79	F279 483.20(d), 483.20(k)(1)	04/08/2011
SS=D	and record rev	iew, the facility			DEVELOP COMPREHENSIVE CARE	
	failed to ensur	e care was planned			PLANS	
	related to wou	nds for 2 of 4			It is the practice of Landmark	
	residents revie	wed related to wound			It is the practice of Landmark  Nursing and Rehabilitation to	use
	care in a samp	le of 7. (Residents D			the results of the assessment	to
	and G)				develop, review and revise the resident's comprehensive plan	
	<i></i>				care.	
	Findings include:					. ,
	1. During the Initial Tour on 3/8/11 at 6:50 p.m., Resident D was				I. Care plans for Resident G were update	
					to reflect current wound treatm	
					interventions. Treatment	
	•				prescriptions for Resident D and G have been reviewed and	na
		The resident indicated			treatments are being provided	as
		ard of hearing and			prescribed and documented o	n
	_	munication with			each resident's Treatment Administration Record.	
	notes written o	on paper she			II. Complete skin chec	ks
	provided. She	indicated she had a			will be completed on all residents. All wounds will be	
	boil on her leg	and pointed to the			identified and assessed by	
	left leg above	the knee. She			licensed nurse. The Treatmer	
	indicated the v	yound dressing was			Administration Records and ca plans for all residents identified	l l
	to be changed	two times a day but			having wounds will be updated	
	_	ways happen. She			include current wound treatme	
		urse applied a triple			interventions. III. LPN #12 will be	
		nent, and the wound			reeducated on skin assessme	·
	was painful wl				physician's orders and notifica	
	•	he indicated when			of physician regarding change skin condition. Wound Evalua	
	she had boils i				and Treatment Policy was	
		• .			reviewed by QA and found to I	
	needed a surg	geon to cut the core			appropriate. All nurses will be reeducated on the provision at	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAIN	OF CORRECTION	155616		LDING		03/09/20		
		100010	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/00/20		
NAME OF F	PROVIDER OR SUPPLIER			201 E E				
	ARK NURSING AND	-		1	LBANY, IN47150			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE	
	out." The resident closed the door to her room, and she pulled her pants below the knees to show the			documentation of treatments as prescribed by physicians. Nurses and Care Plan Coordinator will be reeducated on policy including but				
	pants below the dressing on the was observed a Written on the 2:00 p.m.  The clinical re was reviewed p.m. The reside Minimum Data dated 7/9/10 in was independent for daily decis understand, and herself understand, and herself understand and herself understand and p.m., incorder noted & compress to be BID [twice dail [triple antibiot [symbol for with was observed]].	e knees to show the e wound. A Telfa pad above the left knee. dressing was 3/8/11,  cord for Resident D on 3/8/11 at 10:55  dent's annual a Set assessment endicated the resident ent in cognitive skills ion-making, could d was able to make				g but g of ee ess v o o tition are bed e		
	[amount] of cl	ear drainage noted. tinue] to monitor."						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616		(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/09/2011	
	PROVIDER OR SUPPLIER		201 E E	ADDRESS, CITY, STATE, ZIP COI ELM ST ILBANY, IN47150	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
TAG	No further door note was indicated Notes section of An Interdiscip Note dated 2/1 indicated), indated [symbol for withigh & orders compresses. States Note] of 2/17/documentation indicated in the Progress Note clinical record During intervipum, the Direct (DON) indicated not have a sperbut she or the Nursing (ADC) once a week, documentation	cumentation since this ated in the Nurse's of the clinical record.  linary (IDT) Progress 8/11 (no time icated, "Resident ith] boil present to L received for See NN [Nurse's 11." No further in since the note was the Interdisciplinary section of the cew on 3/8/11 at 9:45 attor of Nursing the facility does cific wound nurse, Assistant Director of ON) look at wounds	TAG		PROPRIATE	DATE
		ministration Record].				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155616		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/09/2011	
	PROVIDER OR SUPPLIER		201 E	ADDRESS, CITY, STATE, ZIP CO ELM ST ALBANY, IN47150		
	SUMMARY S (EACH DEFICIEN REGULATORY OR  currently in ef was in a plasti clinical record Plans of failed for care of the boil on the res  Documentatio Records for Fe March 2011 in ordered for the left thigh was 6:00 a.m. to 2: once on the 2: shift.  During intervi p.m., the DON did not have w policies.  During intervi p.m., the DON spoken with the indicated she have	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  fect for Resident D c sleeve in the . The current Care d to indicate a plan skin related to the ident's left thigh.  n on the Medication ebruary 2011 and dicated the treatment e boil on Resident D's planned once on the 00 p.m. shift and 00 p.m. to 10:00 p.m.  ew on 3/9/11 at 2:30 I indicated the facility written wound care  ew on 3/9/11 at 4:45 I indicated she had	201 E	ELM ST	ECTION OULD BE	(X5) COMPLETION DATE
	_	ot to write it down. cated she could find				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155616		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE S COMPL 03/09/2	ETED	
		100010	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00,00,2	
NAME OF F	PROVIDER OR SUPPLIER			201 E E			
LANDMA	RK NURSING AND	REHABILITATION		NEW AL	_BANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	` ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	rE	COMPLETION DATE
	no documentat	tion to indicate the					
	wound had bee	en assessed since					
	2/17/11. The l	DON indicated she					
	could not find	a Weekly Wound					
	Evaluation Flo	ow Record for					
	Resident D's wound.						
	2. The clinica	l record for Resident					
	G was reviewe	ed on 3/8/11 at 9:40					
	p.m. The resid	dent's diagnoses					
	included, but v	were not limited to,					
		ripheral vascular					
		specified venous					
	insufficiency.						
	Weekly Skin C	Check Sheets for					
	February and I	March 2011 indicated					
	the following:	on 2/5, 2/12, and					
	2/26/11, the as	ssessment indicated					
	the resident ha	d "Open area: Old."					
	Documentation	n failed to indicate a					
	skin assessmer	nt was completed on					
	2/19/11. Docu	mentation on 3/5/11					
	indicated "Skir	n Intact." Weekly					
	Wound Evalua	ntion Flow Records					
	from 1/19/11 t	hrough 3/9/11					
	indicated the r	esident was being					
	treated for a no	on-pressure ulcer to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S COMPL		
THETETAL	or connection	155616	- 1	LDING		03/09/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			201 E E	LM ST		
LANDMA	RK NURSING AND	REHABILITATION		NEW AL	_BANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	the left ankle.						
ı	VII.0 1010 WIII.101						
	A physician's o	order was received on					
		leanse R [right] ankle					
		ith] NS [normal					
	- •	Aquacel AG [alginate]					
		for with] Versiva X					
		nbol for with] Kerlix					
	q [every] 3 days & PRN [as needed]						
	for soiled/dislodged."						
		C					
	Documentation	n in Nurse's Notes					
	from 2/22/11 t	hrough date of					
		Weekly Wound					
		ow Record failed to					
	indicate a desc	cription of the wound.					
ı		•					
	Documentation	n on the Medication					
	Records for Fe	ebruary and March					
	2011 next to th	ne entry for the					
	dressing chang	ge indicated the					
	dressing was c						
	_	es: 2/22, 2/25, 2/26,					
	_	nd 3/3, 3/5, 3/6, and					
	3/7/11.						
	Nurse's Notes	for 2/25/11 at 1:20					
	p.m., indicated	l, "Tx [treatment] to					

PRINTED: 04/04/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155616		(X2) MULTIPLE CC  A. BUILDING  B. WING	NSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED 03/09/2011	
	PROVIDER OR SUPPLIER	REHABILITATION	201 E E	ADDRESS, CITY, STATE, ZIP COD ELM ST LBANY, IN47150	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	ordered." No indicated inforwound to the resident's indicated a prostasis Ulcer to 2/3/10, with mof 1/26/11. Do to indicate a prostation the right ankled buring intervipum, the DON resident's recombout the wouseated at the modicated the recome and go of lots of changes DON telephore #12, who had on day shift or indicated to the a treatment to	Health Care Plan oblem of "Venous the left ankle," dated tost recent Goal date ocumentation failed lan related to care of december of the researched the rd for information and. LPN #3 was arrse's station and desident had wounds on both ankles with as in treatments. The fied the nurse, LPN cared for Resident G an 3/9/11. LPN #12 be DON she provided the resident's left at did not provide the				

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
THIDTEM	or connection	155616	A. BUILI			03/09/2	
			B. WING		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF F	PROVIDER OR SUPPLIER			201 E E			
LANDMA	RK NURSING AND	REHABILITATION		NEW AL	_BANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	l r	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		was "nothing to					
		ON asked LPN #12 if					
	she had obtain	ed a physician's order					
		the dressing, and					
		eated she had not					
	contacted the	ohysician.					
	•	. •					
	Resident G's ri	ight ankle was					
	observed on 3/9/11 after the DON						
	completed the phone conversation						
	with LPN #12.	. The DON and LPN					
	#3 wheeled the	e resident to his room					
	and removed h	nis white sock. Two					
	small areas of	bright red bloody					
	drainage were	on the sock. The					
	_	er right leg was dark					
	red, and the sk	in was shiny. Two					
	open areas ooz	zing clear bloody					
	fluid were obs	erved on the front of					
	the right shin.	A dark purplish					
	_	ne skin was observed					
	on the top of the	he right foot. No					
	dressing was p						
		t ankle. The top of					
	_	malleolus had a					
	_	h a dull dark red					
	center that app	eared firm and					
		ssed. No drainage					
		Č					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155616			MULTIPLE COI	NSTRUCTION		(X3) DATE S COMPL			
		155616	B. WI		-	<del></del>	03/09/2	011		
NAME OF T	DOMDED OF GUIDNIES				DDRESS, CITY, STATE,	, ZIP CODE				
NAME OF F	ROVIDER OR SUPPLIER			201 E ELM ST						
	RK NURSING AND				BANY, IN47150					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN (EACH CORRECTIVE AC			(X5)		
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED T DEFICIE	O THE APPROPRIAT	E	COMPLETION DATE		
		LPN #3 ran her		0				2.1.2		
		e area and indicated								
	_	n. The resident asked								
	_	is in the wound, and								
		im there was not.								
		ted she would obtain								
		rs and care for the								
		ds on the resident's								
	shin.									
	This federal ta	_								
	Complaint IN	00086657.								
	3.1-35(d)(2)(B	3)								
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	6ZJX11	Facility I	D: 001145	If continuation sh	eet Pa	ge 25 of 54		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED
		155616	B. WIN			03/09/2011
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				l	ELM ST	
LANDMA	ARK NURSING AND	REHABILITATION		NEW A	LBANY, IN47150	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
F0282	Based on recor		F02		F282 483.20(k)(3)(ii) SERVICE	
			102	02	BY QUALIFIED	04/08/2011
SS=D	· ·	facility failed to			PERSONS/PER CARE PLAN	
		dent's plan of care			It is the practice of Landmark	
	related to use of	of a specialized			Nursing & Rehabilitation to assure the services provided of	or
	drinking cup w	vas implemented for			arranged by the facility	
	1 of 1 resident	reviewed related to			must be provided by qualified	
	use of a specia	ll cup in a sample of			persons in accordance with each residen	t'e
	7.				written plan of care.	
	/.				'	
	T: 1: : 1	1			I. Resident G was	
	Findings inclu	de:			reassessed for adaptive equipment needs by occupational	
					therapist. Resident G's care p	
	The clinical re	cord for Resident G			and C.N.A. assignment sheet	
	was reviewed	on 3/8/11 at 9:40			were updated to reflect curren adaptive equipment needs.	t
	p.m.				II. All residents will be	
	1				reviewed for the use of	
	Nurse's Notes	for 2/22/11 at 10:30			nutrition/hydration adaptive	
					equipment. Care plans and C.N.A. assignment sheets will	he
		l, "Spoke [symbol for			updated to reflect current	
		earlierShe was			adaptive equipment needs for	
		ut him getting fluids.			those residents requiring nutrition/hydration adaptive	
	Does have a sp	pecial cup he likes to			equipment.	
	use. He does o	drink from a regular			III. An Adaptive Equipmer	
	cup or glass [s	ymbol for with] straw			Policy was drafted, reviewed by	
	^ -	difficultyShe			QA and found to be appropriate Therapy, Nursing and Dietary	le.
		at his 'special cup'			departments will be educated	on
	_	(a) bedside and that			policy	
	· ·	_			IV. The Care Plan Coordinator will review each	
		nis past Friday did not			resident's care plan no less of	ten
		cup @ the desk was			than quarterly and with any	
	his. This nurse	e was verified to be a			significant change in condition	
					All adaptive equipment needs	WIII

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6ZJX11

Facility ID:

001145 If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155616		A. BUII	LDING	NSTRUCTION	(X3) DATE S COMPLI 03/09/20	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE ELM ST LBANY, IN47150		· · ·
(X4) ID PREFIX TAG	[lined out work new nurse here this nurse would his 'special cup assignment she sometime. Su his name on his aware that this agreed. Cup note that the communication indicated, "Rse [occupational] therapy] casele "Comments" so "Utilize cut out on all trays. The cup arrived notified of new device]."  An Occupational occupational indicated, "Campartional occupational oc	sponse to Nursing on, dated 7/13/10, d [resident] on OT and PT [physical oad." The ection indicated, at cups with handles therapy ordered cup today. Dietary of A.D. [assistive of the control of the con		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  be reviewed and modifications will be made to the care plan an eeded to reflect current adaptequipment needs. The DON of designee will review new order daily and revise C.N.A. assignment sheets as needed assure current adaptive equipment needs are communicated to care giving staff. The DON will report to commonthly for 3 months and ther quarterly.  V. COMPLETION DATE: 04/08/2011	s as tive or rs to	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155616			(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED 03/09/2011	
	PROVIDER OR SUPPLIER	REHABILITATION	201 E E	ADDRESS, CITY, STATE, ZIP COD ELM ST LBANY, IN47150	E		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	The Care Plandated 10/7/10, problems included, with dates of 10 (no day indicated were not limit have no S/S [states dehydration." included, but were used in the sippy of the bedside. To would review related to the aresident for the interview on 3 the OT indicated.	were not limited to, sipment: nosey 2 cup."  ew on 3/9/11 at 2:00 ional Therapist (OT) desident G was to cup on his tray and at the OT indicated he the documentation assessment of the e cup. During 6/9/11 at 2:20 p.m., teed the resident's use up was related to					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLL AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					ISTRUCTION		(X3) DATE S COMPL		
THEFTERN	or condition	155616	,LIK.	A. BUILD	ING			03/09/2		
				B. WING OS/09/2011  STREET ADDRESS, CITY, STATE, ZIP CODE						
NAME OF P	PROVIDER OR SUPPLIER				201 E EL		L, ZII CODL			
	RK NURSING AND			NEW ALBANY, IN47150						
(X4) ID		TATEMENT OF DEFICIEN		1	ID	PROVIDER'S PLA	AN OF CORRECTION		(X5)	
PREFIX TAG		CY MUST BE PERCEDED LSC IDENTIFYING INFO		1	REFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED DEFIC	ACTION SHOULD BE TO THE APPROPRIAT TENCY)	E	COMPLETION DATE	
IAG			RWATION	1	IAG				DAIL	
	This federal ta									
	Complaint IN(	0008665 / .								
	3.1-35(g)(2)									
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete	Event ID: 62	<u> </u> ZJX11	Facility ID	D: 001145	If continuation sl	neet Pa	ge 29 of 54	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	ETED
		155616	B. WING			03/09/20	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			201 E F	ELM ST		
	RK NURSING AND	REHABILITATION			LBANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſΈ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG				DATE
F0309	Based on obse	rvation, record	F03	J9	F309 483.25 PROVIDE CARE/SERVICES FOR		04/08/2011
SS=D	review, and interview, the facility				HIGHEST WELL BEING It is the		
	failed to ensur	e wounds were			practice of Landmark Nursing	and	
	assessed and v	vound care needs			Rehabilitation to assure each resident receives and the facili	it.	
	planned and in	nplemented for 2 of 4			provides the necessary care a	· .	
	_	wed related to wound			services to attain or maintain t		
					highest practicable physical,		
	•	le of 7. (Residents D			mental, and psychosocial		
	and G)				well-being, in accordance with		
					comprehensive assessment at plan of care. I. Complete skill		
	Findings inclu	de·			checks and wound assessmen		
	i mamgs mera	<b></b>			were completed for Resident [		
	4 5	7 ::: 1 TD			and Resident G by licensed		
	1. During the	Initial Tour on 3/8/11			nurses. These wound		
	at 6:50 p.m., R	Resident D was			assessments continue to be do weekly and documented in the		
	interviewed.	The resident indicated			Residents' clinical records on t		
	she was very h	nard of hearing and			Weekly Wound Evaluation Flo		
					Record by licensed nurses.		
	-	munication with			Treatment orders for Resident		
	notes written o	on paper she			and Resident G were reviewed IDT. Treatments are being	עס ג	
	provided. She	indicated she had a			delivered as prescribed and		
	boil on her leg	and pointed to the			documented on each resident'	s	
	left leg above	-			Treatment Administration		
					Record. Care plans for Reside		
		vound dressing was			D and Resident G were update to reflect current wound treatm		
	to be changed	two times a day but			interventions. II. Complete sl		
	that did not alv	ways happen. She			checks will be completed on a		
		aurse applied a triple			residents. All wounds will be		
		ment, and the wound			identified and assessed by		
					licensed nurse. This assessm will be documented in the	ent	
	was painful wl				residents' clinical records on the	ne l	
	squeezed it. S	he indicated when			Weekly Wound Evaluation Flo		
	she had boils i	n the past, she			Record. Weekly reassessmer		
		_			by licensed nurses is ongoing	and	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPL	ETED
		155616	B. WIN			03/09/2	011
			_		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF	PROVIDER OR SUPPLIEF	ę.		201 E E	ELM ST		
	ARK NURSING AND			<u>.</u>	LBANY, IN47150		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	+	TAG	documented in the residents'		DATE
	1	geon to cut the core			clinical records on the Weekly		
	out." The resi	dent closed the door			Wound Evaluation Flow Recor	d.	
	to her room, a	nd she pulled her			All wound treatment orders will reviewed. The Treatment	ll be	
	pants below th	ne knees to show the			Administration Records and ca	are	
	dressing on th	e wound. A Telfa pad			plans for all residents identified		
	1	above the left knee.			having wounds will be updated	d to	
					include current wound treatme		
	1	e dressing was 3/8/11,			interventions. III. LPN #6 will reeducated on the provision of		
	2:00 p.m.				clean dressing changes, infect		
					control practices including but		
	The clinical re	ecord for Resident D			limited to the use of PPE, and		
	was reviewed	on 3/8/11 at 10:55			wound assessment. LPN #12	will	
					be reeducated on skin assessment, physician's order	·e	
	p.m. The resid				and notification of physician	3	
		a Set assessment			regarding changes in skin		
	dated 7/9/10 is	ndicated the resident			condition. Wound Evaluation		
	was independe	ent in cognitive skills			Treatment Policy (includes Cle		
	for daily decis	sion-making, could			Dressing Change Procedure) reviewed by QA and found to I		
	1	nd was able to make			appropriate. All nurses will be		
	1				reeducated on the Clean		
	herself unders	1000.			Dressing Change and Wound		
					Evaluation and Treatment Policies. Care Plan Coordinat	or	
	A Nurse's Not	e dated 2/17/11 at			will be reeducated on care	.51	
	12:30 p.m., in	dicated, "N.O. [new			planning of current wound		
	1 * 1	t faxed for warm			treatment interventions. All		
	1 -	oil on L [left] thigh			nurses will be reeducated on t provision and documentation of		
	1 -	<del>-</del>			treatments as prescribed by	<b>-</b> 1	
	BID [twice daily] then apply TAO [triple antibiotic ointment] & cover [symbol for with] telfa. Area				physicians. Nurses will compl	ete	
					skin checks and treatments as		
					prescribed by physicians. The treatments will be documented		
	around boil re	ddened, scant amt			rendered on the front of each	u a5	
	1	lear drainage noted.			resident's Treatment		
					Administration Record. Resul	ts	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155616	A. BUI	LDING			
		155010	B. WIN			03/09/2	011
NAME OF	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
LANIDAA	ADIZ NILIDOINO ANI			1	ELM ST		
		) REHABILITATION		NEWA	LBANY, IN47150		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAG	+		+	IAG	of skin checks will be		DATE
	_	tinue] to monitor."			documented in the residents		
	No further do	cumentation since this			clinical record. C.N.A.'s will		
	note was indic	cated in the Nurse's			continue to complete skin		
	Notes section	of the clinical record.			documentation with each show and turn in completed shower		
					sheets to nurse. Nurse will		
	An Interdiscin	olinary (IDT) Progress			review these sheets for any		
	1 *	• • •			changes in skin condition not		
	1	18/11 (no time			identified through prescribed s checks. Should a wound be	skin	
	indicated), ind	licated, "Resident			identified by any means, the		
	[symbol for w	rith] boil present to L			nurse will assess the wound a	nd	
	thigh & orders	s received for			document the assessment on		
	T -	See NN [Nurse's			Weekly Wound Evaluation Flo		
	_	'11." No further			Record. A competency check for Clean Dressing Changes v		
	_				drafted and approved by QA.	vas	
		n since the note was			IV. The DON will review show	/er	
	indicated in th	e Interdisciplinary			sheets daily. The DON will		
	Progress Note	section of the			oversee the IDT review of wounds no less often than		
	clinical record	L.			weekly. This review will include	de.	
					but not be limited to visualizati		
	The Medicatio	on December and Westeley			of the wound, review of treatm	ent	
		on Record and Weekly			orders, review of treatment administration records to assu	ıro.	
		heet for February			treatments are being	ile	
	2011 indicated	d no skin assessment			administered as prescribed,		
	was completed	d as scheduled on			wound assessment		
	2/19/11. The	Weekly Skin Check			documentation and care planr of current wound treatment	ning	
		d the resident had an			interventions. The DON or		
		Old" on the right thigh			designee will complete Clean		
	_				Dressing Change Competency		
		d an unsigned,			Checklists with all nurses initial and then no less often than	ally	
	undated "Wee	kly Skin Check			and then no less often than annually thereafter. The DON	will	
	Sheet" in the I	Medication Record			report to QA monthly for 3 monthly		
	Binder at the i	medication cart for			and then quarterly. V.		
		-			COMPLETION DATE:		
					04/08/2011		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155616			(X2) MULTIPLE CC  A. BUILDING  B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY  COMPLETED  03/09/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  201 E ELM ST  NEW ALBANY, IN47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	Resident D's h boil R [right] t	all indicated: "Other thigh."					
	p.m., the Direct (DON) indicated not have a special but she or the Nursing (ADC) once a week. documentation notes or on sk [Treatment Accorded Treatment Accorded Tre	ew on 3/8/11 at 9:45 ctor of Nursing ted the facility does cific wound nurse, Assistant Director of DN) look at wounds She indicated In would be in IDT in sheets on the TAR Iministration Record].  In related to care fect for Resident D is sleeve in the I. The current Care indicate a plan skin related to the ident's left thigh.  In on the Medication bruary 2011 indicated ordered for the boil is left thigh was on the 6:00 a.m. to it and once on the 2:00					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE S COMPL	
		155616	A. BUI B. WIN	LDING NG		03/09/2	011
NAME OF F	PROVIDER OR SUPPLIER	<del>"</del> ·	<u>'</u>		DDRESS, CITY, STATE, ZIP CODE	•	
LANDMA	ARK NURSING AND	REHABILITATION		201 E E NEW AL	LM ST LBANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION DATE
	p.m. to 10:00 j	p.m. shift. The					
	record indicate	ed the treatment was					
	administered of	only one time instead					
	of two times o	n 2/27/11.					
		n on the Medication					
		arch 2011 indicated					
		was planned as in					
	February 2011						
	indicated the tr						
		only one time instead					
	of two times o	n 3///11.					
	On 3/9/11 at 1	2:50 p.m., LPN #6					
	was observed	•					
	l -	esident D's left thigh.					
	LPN #6 gather	red supplies including					
	a washcloth, tu	abe of triple antibiotic					
	ointment, pack	kaged Telfa pad, and					
	tape and went	to the resident's					
	room. LPN #6	donned disposable					
	gloves when R	Resident D's					
	roommate requ	uested assistance with					
		LPN #6 assisted the					
		h her slippers, and the					
	_	uested to be wheeled					
		. LPN #6 wheeled					
	her out and ret	turned to the room.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION	li '	(X3) DATE SURVEY COMPLETED	
		155616	A. BUILDING B. WING		03/09/	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		ADDRESS, CITY, STATE, ZIP COD	DE L	
				ELM ST		
	ARK NURSING AND			.LBANY, IN47150		1
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOWN	ULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	DATE
	She removed t	the disposable glove,				
		rashing her hands,				
	donned anothe	er pair. She took the				
	washcloth to the					
	bathroom and	wet it. Resident D				
	1	ts below the knees,				
		ng on the left thigh				
	indicated 3/8/3	11, 8:15 p.m. LPN #6				
		oiled dressing. The				
	resident indica	ated the wound was				
	itching, but "I	know not to touch				
	it." The reside	ent indicated, "It				
	looks like it's	filling back up." LPN				
	#6 applied the	washcloth to the leg,				
	and the reside	nt stated, "I remember				
	when I was yo	oung, we would use a				
	hot compress.	" LPN #6 removed				
	_	l without washing her				
	hands donned	another pair. The				
	nurse knelt be	side the resident, and				
	1 1	Telfa and tape were				
	l ^	floor. The nurse				
	removed the w	vashcloth from the				
	resident's leg a	and indicated there				
	l .	ge. The wound was				
	observed to be	e white/yellow in the				
		ided by a red rim and				
	dark around th	ne edges under the				
<u> </u>						-1

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPI	
		155616	A. BU B. WII			03/09/2	011
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	1		DDRESS, CITY, STATE, ZIP CODE		
				201 E E			
	ARK NURSING AND				_BANY, IN47150		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
	skin. During	interview at this time,					
	LPN #6 indica	ted documentation					
	should be in the	ne record about the					
	· ·	nd she indicated she					
		current size by					
		umb to the first					
		middle finger to					
		oximate size of the					
		#6 dispensed the					
	_	c ointment onto her					
	~	the wound, and					
	_	e of ointment onto the					
	•	resident's overbed					
	table. She the						
	dressing, taped						
		nitials] 6-2" and drew					
	a smiley face of	on the dressing.					
	<b>.</b>	2/0/11 / 2 20					
		ew on 3/9/11 at 2:30					
	1 1	I indicated the facility					
		vritten wound care					
	1 ^	indicated related to					
		the wound that a					
		vrite what she sees.					
		wed a Weekly Wound					
		w Record for another					
		ndicated she would					
	expect to see t	he information there					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPI	
		155616	A. BU B. WI			03/09/2	2011
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	<u> </u>	1	ADDRESS, CITY, STATE, ZIP CODE		
	ARK NURSING AND		201 E ELM ST NEW ALBANY, IN47150				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	-DANT, 11447 100		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	IAIE	DATE
		sessment. Review of					
	the Flow Reco						
		cluding stage, length,					
	_	oth, presence of					
		exudate type and					
		description, and					
		kin color and type.					
	The DON indi	cated the facility did					
	not have a spe	cific policy related to					
	how to do a cle	ean dressing change,					
	and asked for	the identification of					
	the resident w	hose dressing change					
	was observed,	so she could					
	"educate the n	urse."					
	_	ew on 3/9/11 at 4:45					
		I indicated she had					
	1 *	nurse, who told the					
	DON she had	measured the					
	resident's wou	nd when it was first					
	noted, but forg	got to write it down.					
	The DON indi	cated she could find					
	no documenta	tion to indicate the					
	wound had be	en assessed since					
	2/17/11. The	DON indicated she					
	could not find	a Weekly Wound					
	Evaluation Flo	ow Record for					
	Resident D's w	vound.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
THIS TETRIC	or connection	155616	A. BUI			03/09/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			201 E E			
LANDMA	RK NURSING AND	REHABILITATION		NEW AL	_BANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE C	OMPLETION DATE
	negozinom on	250 122.111 111.10 11.11 01.111 11101.1)					5.112
	2 The clinical	l record for Resident					
		ed on 3/8/11 at 9:40					
	p.m. The resid	dent's diagnoses					
	-	vere not limited to,					
	f f	ripheral vascular					
		specified venous					
	insufficiency.	•					
	Weekly Skin C	Check Sheets for					
	February and I	March 2011 indicated					
	the following:	on 2/5, 2/12, and					
	2/26/11, the as	sessment indicated					
	the resident ha	d "Open area: Old."					
		n failed to indicate a					
	skin assessmer	nt was completed on					
	2/19/11. Docu	mentation on 3/5/11					
	indicated "Skir	n Intact." Weekly					
	Wound Evalua	tion Flow Records					
	from 1/19/11 t	hrough 3/9/11					
		esident was being					
		on-pressure ulcer to					
	the left ankle.	_					
	A physician's o	order was received on					
	2/22/11 for "C	leanse R [right] ankle					
		ith] NS [normal					
	- *	Aquacel AG [alginate]					
	- 11 -	,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155616		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED 03/09/2011		
		155616	B. WING			03/09/2	011
	PROVIDER OR SUPPLIER ARK NURSING AND			201 E E			
	summary s (EACH DEFICIENT REGULATORY OR COVER [Symbol C & wrap [syr q [every] 3 days for soiled/disloted from 2/22/11 to review or on a Evaluation Flowing indicate a description on the following summary of the following summary of the summary of	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  for with] Versiva X mbol for with] Kerlix ys & PRN [as needed]		STREET A		NTE .	(X5) COMPLETION DATE
	p.m., indicated bilat [bilateral ordered." No indicated infor wound to the r	for 2/25/11 at 1:20 d, "Tx [treatment] to ] ankles completed as other Nurse's Notes rmation about the right ankle.  Health Care Plan					

NAME OF PROVIDER OR SUPPLIER  LANDMARK NURSING AND REHABILITATION  (XS) ID  SUMMARY STATEMENT OF DEFICIENCY  (RECH DEPICIENCY MUST BE PERCEDED BY FULL  TAG  indicated a problem of "Venous  Stasis Ulcer to the left ankle, dated 2/3/10, with most recent Goal date of 1/26/11. Documentation failed to indicate a plan related to care of the right ankle.  During interview on 3/9/11 at 4:45 p.m., the DON researched the resident's record for information about the wound. LPN #3 was seated at the nurse's station and indicated the resident had wounds come and go on both ankles with lots of changes in treatments. The DON telephoned the nurse, LPN #12, who had cared for Resident G on day shift on 3/9/11. LPN #12 indicated to the POON she provided a treatment to the resident's left ankle today but did not provide the treatment to the right ankle, because there was "nothing to treat." The DON asked LPN #12 if she had obtained a physician's order to discontinue the treatment, and LPN #12 indicated she had not contacted the physician.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155616			(X2) MULTIPLE CC  A. BUILDING  B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY  COMPLETED  03/09/2011		
PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG				201 E ELM ST					
Stasis Ulcer to the left ankle," dated 2/3/10, with most recent Goal date of 1/26/11. Documentation failed to indicate a plan related to care of the right ankle.  During interview on 3/9/11 at 4:45 p.m., the DON researched the resident's record for information about the wound. LPN #3 was seated at the nurse's station and indicated the resident had wounds come and go on both ankles with lots of changes in treatments. The DON telephoned the nurse, LPN #12, who had cared for Resident G on day shift on 3/9/11. LPN #12 indicated to the DON she provided a treatment to the resident's left ankle today but did not provide the treatment to the right ankle, because there was "nothing to treat." The DON asked LPN #12 if she had obtained a physician's order to discontinue the treatment, and LPN #12 indicated she had not	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	COMPLETION		
		Stasis Ulcer to 2/3/10, with mof 1/26/11. Do to indicate a pit the right ankled.  During intervipum, the DON resident's recomposed at the moderated at the mode	the left ankle," dated lost recent Goal date ocumentation failed lan related to care of lan related to care of lan related to care of lan researched the researched the researched the resident had wounds on both ankles with so in treatments. The led the nurse, LPN cared for Resident G lan 3/9/11. LPN #12 led DON she provided the resident's left let did not provide the registrankle, was "nothing to DN asked LPN #12 if led a physician's order the treatment, and leated she had not						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155616	A. BUII B. WIN			03/09/2	2011
NAME OF	PROVIDER OR SUPPLIEI	R	•	STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
LANDMA	ARK NURSING AND	REHABILITATION		1	_BANY, IN47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	observed on 3 completed the with LPN #12 #3 wheeled the and removed I small areas of on the sock. Tright leg was was shiny. Two clear bloody for the front of the purplish blotco observed on the dressing was president's right the outer mall red center that slightly depressed was observed fingers over the twas not ope if there was purple LPN #3 told he LPN #3 indicate treatment order.	right ankle was /9/11 after the DON e phone conversation 2. The DON and LPN he resident to his room his white sock. Two bright red blood were the resident's lower dark red, and the skin to open areas oozing luid were observed on he right shin. A dark h under the skin was he top of the foot. No present on the he tankle. The top of he eolus had a dull dark he appeared firm and he ssed. No drainage he LPN #3 ran her he area and indicated					

PRINTED: 04/04/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155616				LDING	NSTRUCTION	(X3) DATE (COMPL 03/09/2	ETED
NAME OF PROVIDER OR SUPPLIER  LANDMARK NURSING AND REHABILITATION			p. wiiv	STREET A	DDRESS, CITY, STATE, ZIP CODE LM ST LBANY, IN47150	I	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	shin.	,					
	This federal ta Complaint IN						
	3.1-37(a)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPLETED	
		155616	B. WING		- <u></u> -	03/09/2011	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				201 E E			
LANDMA	RK NURSING AND	REHABILITATION	NEW ALBANY, IN47150		LBANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
F0441			F04		F441 483.65 (a) INFECTION		04/08/2011
		rvation, interview,	1 04	T1	CONTROL PROGRAM		04/08/2011
SS=F		iew, the facility					
	_	ment the policies and			It is the practice of Landmark Nursing and Rehabilitation to		
	procedures of	its infection control			maintain an infection control		
	program relate	ed to collecting,			program designed to provide a		
	analyzing, and	acting on infection			safe, sanitary and comfortable		
		This deficient practice			environment and the help prev the development and	eni	
		ial to affect 74 of 74			transmission of disease and		
	_	ing at the facility.			infection.		
		so failed to ensure			I. The DON was provid	ded	
					with and educated on current		
	staff followed	_			Infection Control Policies &		
		and glove use and			Procedures by corporate nurse consultant. Infection Control lo		
	dressing suppl	ies during dressing			were updated to reflect infection	- 1	
	change for 1 or	f 2 observations of			processes present in the facilit	:y	
	wound care. (	Resident D) The			from January 1, 2011 to March	۱	
	facility also fa	iled to ensure			22nd by corporate nurse consultant. This log will be		
	-	n of procedure of			updated daily as infections are	,	
	_	n clinical records			identified by DON or designee		
					Monthly Infection Report for Al Nursing Units was completed to		
		tion precautions for			January and February 2011 by		
		s reviewed related to			corporate nurse consultant. N	o	
	_	utions in a sample of			trends were identified. Isolation	n	
	7. (Residents	C, E, G, and H)			stickers were placed on the charts for Resident C & G.		
					Resident's E and H no longer		
	Findings inclu	de:			require isolation. Resident D h	nas	
	J				been assessed and shows no signs or symptoms of infection	.	
	1 On 3/9/11 a	at 12:30 p.m., the			Care plans for Resident C, D,		
		rrsing (DON) was			E and H have been reviewed a		
		• , ,			updated to include current infection control needs.		
	requested to pr	rovide policy and			II. All residents were	l	
					55.555 6.6		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155616	B. WIN			03/09/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	•		201 E E	ELM ST		
	ARK NURSING AND				LBANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
IAG		ted to the facility's		TAG	reviewed for the presence of	DATE	
	1 *	•			infection. Those residents wit	h	
		rol program and			identified infections were place	ed	
	documentation	related to the			on the Infection Control Log.	wod	
	facility's collec	cting, analyzing, and			Physician's orders were review and found adequate to treat	weu	
	acting on infec	ction control			currently identified infections.		
	_	uch as infection			Those residents with infection	I	
	control logs.	dell us illicetion			requiring isolation were review		
	Connorrogs.				Stickers were placed on charts and care plans were updated.	5	
					III. Infection Control		
	On 3/9/11 at 1	2:50 p.m., the DON			Policies and Procedures were	I	
	showed a bind	er containing			reviewed by QA and found to	be	
	print-outs fron	n the facility's lab			appropriate. All staff will be reeducated on infection control		
	1 ^	ating lab results for			policies. Clean Dressing Cha	I	
	_	-			Policy was reviewed by QA ar	-	
	_	ares with dates from			found to be appropriate. LPN		
	·	gh 2/28/11. The			will receive 1:1 reeducation or clean dressing changes include		
	print-outs indi	cated the information			but not limited to use of PPE a	-	
	was faxed fror	n the lab to the			hand washing. Nurses will be		
	facility on 3/4/	11. At this same			reeducated on Clean Dressing		
	· ·	I indicated the facility			Change Policy. The DON was provided with and educated or		
	· ·	nformation to help in			current Infection Control Police		
		-			& Procedures by corporate nu		
	implementatio				consultant. Infection Control I	· 1	
	1 1	e new Infection			were updated to reflect infection processes present in the facility		
	Control Progra	am, which began in			from January 1, 2011 to March		
	January 2011.	The DON also			22nd. This log will be updated		
	· ·	es of blank forms			daily as infections are identified		
	with revision date of 10/2010,				Monthly Infection Report for A Nursing Units was completed		
					January and February 2011.		
	which the DON indicated would be used for gathering and analyzing			report will be completed month			
				by DON or designee. A			
	data related to infections in the				competency checklist for Clea Dressing Changes was drafted		
					Diessing Changes was dialler	u	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY  COMPLETED	
		155616	B. WIN	G		03/09/2011	
	PROVIDER OR SUPPLIER		•	201 E E	ADDRESS, CITY, STATE, ZIP CODE ELM ST LBANY, IN47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR facility. The f month reports	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  Orms were month by and included cluding, but not		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  and approved by QA.  IV. DON or designee wi update Infection Control Log daily. QA will review Infection	II	(X5) COMPLETION DATE
	limited to, resinumber, signs physician diagrand comments skin, including wounds, fungatherpes simpler scabies; gastroinfections; eye mouth infections, including with catheter. Also summary type "Monthly Infe Nursing Units' breakdown by types of infect the DON was the tracking sinew document	dent name, room and symptoms, nosis, culture results, for infections of the g cellulitis/soft tissue al skin infections, k, herpes zoster, and bintestinal tract c, ear, nose, and ons; systemic luding common cold influenza-like inary tract infections, and without included was a form entitled, ction Report for All " with columns for unit of the various ions. At this time, requested to provide ince prior to use of the			Control Log weekly for four weeks, monthly for two month and then quarterly. DON or designee will complete Month Infection Control Report for Al Nursing Units monthly. QA w review this report monthly for three months and then quarte The DON or designee will complete Clean Dressing Cha Competency Checklists with a nurses initially and then no les often than annually thereafter. V. COMPLETION DAT 04/08/2011	s ly l ill rly. inge ill ss	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155616				LDING	NSTRUCTION	(X3) DATE : COMPL 03/09/2	ETED
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	D. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	ARK NURSING AND			201 E E	LM ST LBANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	_ ·	ctor of Nursing again					
		acility was in process					
		ng a company-wide					
		rol Program which irst of the year, 2011.					
		ne DON provided					
	l '	of print-outs she					
	1 ^	e provided to her by					
		boratory provider.					
	·	licated run dates for					
		1 2/28/11. The DON					
	_	nad highlighted the					
		cimen collection date					
		en cultures obtained.					
	_	use of the data					
		ns provided by the					
		at company had not					
	been implemen	nted. She also					
	indicated an Ir	nfection Control					
	Committee had	d not met to analyze					
	and act on the	data provided by the					
	lab for the mor	nths since September					
	2010.						
		0 11: 1 115 11:					
		facility's "Policies					
		- Infection Control,"					
	_	/9/11 at 2:30 p.m., by					
	the DON, who	indicated the policy					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6ZJX11

Facility ID:

001145

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155616		(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/09/2011	
	PROVIDER OR SUPPLIER		201 E E	ADDRESS, CITY, STATE, ZIP COD ELM ST LBANY, IN47150	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	infection control practices are to investigate, and in the facility. Assessment are Committee, the Control Commitmentation policies and process and process and fast should be refered Control Coord Nursing Service.  2. Review of "Multidrug-Reprovided on 3, the DON, who was in effect services indicated: " be placed on Complement the	The objectives of our rol policies and of a. Prevent, detect, and control infections 3. The Quality and Assurance rough the Infection enittee, shall oversee on of infection control ractices6. Inquiries are infection control ractices6. Inquiries are infection control ractices6. Inquiries are infection control ractices6. Infection linator or Director of ces.  The facility's resistant Organisms," (9/11 at 2:30 p.m., by a indicated the policy lince 1/1/11, 9. Should a resident Contact Precautions of following:f. Place its sign/stickers on the				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPI	
		155616	B. WI			03/09/2	2011
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	<u> </u>		ADDRESS, CITY, STATE, ZIP CODE		
	ARK NURSING AND	DREHARII ITATI∩N	201 E ELM ST NEW ALBANY, IN47150				
(X4) ID		TATEMENT OF DEFICIENCIES		ID ID	LDAN1, IN47 150		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	1	Tour of the facility on					
		p.m., signs indicating					
		ORT TO NURSE					
		ΓERING" were					
		ne doors of the rooms					
		G, E, and H. The sign					
	1 ^	ed on the top of a					
	l ^	bin outside the room					
	of Resident C.						
	Daning internsi	2/0/11 -4.0-25					
	1	ew on 3/8/11 at 8:25					
	<del>*</del>	indicated Resident C					
		et Precautions due to					
	1	a wound to the back A (methecillin					
		ylococcus aureus)					
	positive. Duri	•					
	l <sup>-</sup>	en asked about the					
	1	or of Resident G,					
	1	l a chart from the					
	1 ^	ne chart was for					
		oommate. The nurse					
		many pages of the					
		cated, "I'm finding out					
		ings here, but not					
		nat I'm looking for."					
	· ·	the Assistant Director					
	1 -	cated the STOP sign					
		Č					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155616		(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING		COM	(X3) DATE SURVEY COMPLETED 03/09/2011			
NAME OF PROVIDER OR SUPPLIER  LANDMARK NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE  201 E ELM ST  NEW ALBANY, IN47150					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
	on Resident G's door was related to Resident G's care.  A. The clinical record for Resident G was reviewed on 3/8/11 at 9:40 p.m. The record failed to indicate a sticker on the chart to alert staff to the resident's isolation precautions.  B. The clinical record for Resident E was reviewed on 3/8/11 at 9:30 p.m. The record failed to indicate a sticker on the record to alert staff to the resident's isolation precautions.  C. The clinical record for Resident C was reviewed on 3/8/11 at 9:10 p.m. The record failed to indicate a sticker on the record to alert staff to the resident's isolation precautions.  D. The clinical record for Resident H was reviewed on 3/9/11 at 5:30 p.m. The record failed to indicate a sticker on the chart to alert staff to the resident's isolation precautions.							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		COM	(X3) DATE SURVEY COMPLETED 03/09/2011			
NAME OF PROVIDER OR SUPPLIER  LANDMARK NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE  201 E ELM ST  NEW ALBANY, IN47150					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE		
	need to "sit and chart to determine related to a respectations. So chart did not he to look for the same as observed treatment to R LPN #6 gather a washcloth, to ointment, pack tape and went room. LPN #6 gloves when Frommate required from the room the resident our room. She rerigioves, and with hands, donned Resident D put	at 12:50 p.m., LPN #6 providing the esident D's left thigh. red supplies including abe of triple antibiotic raged Telfa pad, and to the resident's 6 donned disposable Resident D's uested assistance with LPN #6 assisted the h her slippers, and the uested to be wheeled at and returned to the moved the disposable thout washing her						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155616		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		СОМ	(X3) DATE SURVEY COMPLETED 03/09/2011			
NAME OF PROVIDER OR SUPPLIER  LANDMARK NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE  201 E ELM ST  NEW ALBANY, IN47150					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE		
	washing her hapair. The nurs resident, and tape were LPN #6 disperantibiotic oint and the wound of ointment or resident's over applied the drew wrote "3-9-11 drew a smiley The nurse rem without washi room.  On 3/9/11 at 2 Administrator indicated are utrain employed infections con policies indicated to persequipment (PIThe information)	cloves and, without ands, donned another see knelt beside the he packaged Telfa placed on the floor. Insed the triple ment onto her glove late, and placed the tube and to the leg/foot of the abed table. She then the essing, taped it, and [her initials] 6-2" and face on the dressing. The above her gloves and, and her hands, left the covered policies she are an orientation to						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155616		A. BUILDING B. WING			COMPI 03/09/2	LETED		
NAME OF PROVIDER OR SUPPLIER  LANDMARK NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE  201 E ELM ST  NEW ALBANY, IN47150					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA TAG DEFICIENCY)		Е	(X5) COMPLETION DATE		
	before donning PPE."	g and after removing						
	2:30 p.m., the facility did not policy related clean dressing for the identifit whose dressing	he could "educate the g relates to 00086657.						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
155616		B. WING			03/09/2011		
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
			201 E ELM ST				
LANDMA	RK NURSING AND	REHABILITATION		NEW A	LBANY, IN47150		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE	
F0514	Based on recor		F05		F514 RESIDENT RECORDS-	04/08/2011	
			1		COMPLETE/ACCURATE/ACC		
SS=D	ĺ	facility failed to			SSIBLE		
	ensure the resi	dent's record was			It is the proptice of Landreson.		
	accurate relate	d to care in the event			It is the practice of Landmark Nursing & Rehabilitation to		
	the resident's h	neart or breathing			maintain clinical records on ea	ıch	
	stopped. The	deficient practice			resident in accordance with		
		resident reviewed			accepted professional standar and practices that are complet		
		e status in a sample of			accurately documented; readil		
	7. (Resident D	-			accessible; and systematically	, I	
	/. (Resident D)				organized.		
	Findings include:				I. Resident D's clinical		
					record was reviewed. A sticke		
					was placed on the chart indica	iting	
	The clinical re	cord for Resident D			"DNR" status. Resident D's physician was contacted and		
	was reviewed	on 3/8/11 at 10:55			orders were received for "DNR	<b>\</b> "	
	p.m.				status as indicated in Residen	l I	
	•				s advance directives. Resider s care plan was updated to ref		
	   Taned inside tl	ne front cover of the			current code status.		
	•	ellow sticky note			II. All residents' records	3	
	_	•			were reviewed for advance		
		ed, "DNR [do no			directives. All residents' physician's orders were review	ved	
	resuscitate] sta	itus 1/20/2011."			and new orders were received		
					necessary to reflect residents		
	The physician'	s orders for 2/1/11			advance directives. Stickers for those residents opting for "DN	l I	
	through 2/28/1	1 and 3/1 through			status were placed on charts.		
	3/31/11 included, but were not limited to, "Code status: Full code."  In the Advance Directives section				resident care plans were		
					reviewed and updated to reflect current code status.	π	
					III. Advance Directives		
					Policy was reviewed by QA an		
					found to be appropriate. Nurse C.N.A.'s and Care Plan	es,	
	in the Advance	e Directives section			Coordinator will be reeducated	d on	

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S COMPLI		
155616		A. BUILDING  B. WING			03/09/2011		
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE	Į.	
LANDMARK NURSING AND REHABILITATION				1	LBANY, IN47150		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE
	of the record v				policy IV. The Care Plan		
		Form with a check			Coordinator will review each resident's care plan no less of	ton	
		ox for: "No Code.			than quarterly. This review wil		
	C.P.R. [cardio	or basic life support]			include but not be limited to Co Status. Care plans will be revi		
		tiated." A signed			as necessary to assure the		
		der dated 1/20/11 at			current reflection of each resident's code status and		
		s attached to the form			stickers placed on the clinical	.	
	and indicated,				record as appropriate. Physic Order Sheets will be reviewed		
					monthly by DON or designee.		
	The Care Plan Worksheet, dated				This review will include but not limited to Code Status. New	t be	
	1/14/11, indica	ated, "The resident's			orders will be received and	.	
	code status has	code status has been designated as a FULL CODE."			reflected on the Physician's Or Sheets as necessary to reflect		
	FULL CODE.				each resident's current code status. All new orders will be		
	<b>.</b>	During interview on 3/9/11 at 4:00			reviewed by IDT daily. This		
					review will include but not be limited to code status, stickers		
	1 1	ctor of Nursing c've been working on			and care plans. The DON or		
	Í	s in the records."			designee will report to QA monthly for 3 months and ther	,	
	the code status	in the records.			quarterly.		
	3.1-50(a)(2)				COMPLETION DATE: 04/08/2011		